



HISTORY OF IMMUNIZATIONS

State Form 49445 (R2 / 7-07) / BCC 0036

HISTORY OF IMMUNIZATIONS AND TEST *(indicate month and year)*

	1	2	3	4	5
DTaP / DT					

	1	2	3	4
Hib				

	1	2	3	4	5
IPV (Polio)					

	1	2	3	4	5
* Influenza (Flu)					

	1	2
Measles Mumps Rubella (MMR)		

	1	2	3
Rotavirus (RGE)			

	1	2
Varicella (Varivax)		

or Chicken Pox Disease

Month / year

	1	2	3	4
Pneumococcal (PCV) (Prevnar)				

	1	2
HEPA		

	1	2	3
HBV (HEP B)			

* Recommended yearly.

Name of physician / nurse practitioner completing form <i>(please print)</i>	Telephone number ()
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Signature of physician / nurse practitioner

Name of child	Date of birth <i>(month, day, year)</i>	Age
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Name of child care facility	County
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ADDITIONAL NOTES AND INSTRUCTIONS
